Leicester, Leicestershire and Rutland (LLR) Primary Care Funding Model

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“A key purpose of the Integrated Care System is to reduce health inequity. This requires us to ensure there is better alignment of the funding of services to population health need”

Dr Bola Owolabi – Director – Health Inequalities NHSE/I

But…

- Existing primary care funding formula is problematic
  - Ecological fallacy, deprivation match not good, issues like communications barriers unrecognised
- 3 CCGs to 1 ICS
  - Huge range of deprivation, ethnicity, locations
- Previous efforts to make funding fairer lacked a coherent narrative
  - Challenge to PMS funding, attempts guarantee at baseline in City

Rolling back a bit...

- Previous work with ACG system
  - Used as a risk tool for Avoiding Unplanned Admissions enhanced services 2017
  - Started asking if we can use it to case mix our primary care populations to make more meaningful comparisons between practices
  - ACG system is powerful and comprehensive enough to do this
  - Primary care data is of variable coding quality
  - and this distorts case mix output
  - but in predictable way, which we learnt to control for
  - by minimising the effects of coding variation
  - thus maximising the power of ACG giving us a case mix system

So...

A working group was set up and rose to the challenge: create a fair funding formula

1. The maturation of big (local) data in the NHS
2. The maturation of tools to tame the huge complexity
3. Our work in Leicester to compensate for the coding deficits that distort case mix adjustment
4. The finance team leadership securing funding needed

Resulting in ...

Component of Model	Description	% of Total
Core funding component	• A fixed sum based on essential functions and fixed costs, common to all practices.	41.3%
Needs-based funding component	• A variable sum based on patients' needs using a casemix-adjusted methodology (driven by the ACG System). This element is the largest part of this component of the funding model. • A further adjustment for patient turnover. • A further adjustment for communications issues.	52.9%
Deprivation component	• Based on practice level Index of Multiple Deprivation[2] (IMD) derived from postal code areas or registered patients.	5.9%

Needs-based funding component...

- We already know numbers in each coding-adjusted case mix cell
- We lacked a currency of need
- We opted for ‘expected primary care appointment demand’
- Which is the aggregate of weighted demand for a given ACG cell x the number of patients in that cell
- Where the weighted demand is derived from observed appointment activity (in 260,247 SystmOne patients) linked to ACG cell, for well-coded practices

Needs-based funding component...

- The expected primary care appointment demand is then modified further for: -
  - Turnover
  - Communications issues

Results...

- The formula was approved and implemented from July 2021 for an initial period of three years
- £114.6m of money deemed in-scope was distributed between 130 primary care providers for LLR's 1.16 million patients
- 76 primary care providers got increases in funding attributable to the new funding model for totalling £2.8m

And in the real world?

- Because the old formula is not patient-level data based, if a practice selectively attracts only the low need patients of a particular age/sex group, it will increase its profitability; aka ‘cream-skimming’
- This was observed in a pair of city practices where the old formula funded one practice only 1.9% higher than the other, despite our funding formula assessing need as 17% higher in the first
- This was related to inter-practice patient transfers from the second to the first, driven by a better patient consultation experience
- This has been corrected by the new formula but is invisible to the old

Questions?

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